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Webinar

"Marketplace – Know Your Rights 101: How to Appeal a Denial of Coverage or Eligibility of People with Chronic Conditions"

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Stephen H. Clark, CBC, CCP
Home Team Captions
1001 L Street NW, #105
Washington, DC 20001
202-669-4214
855-669-4214 (toll-free)
sclark@hometeamcaptions.com
info@hometeamcaptions.com

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>> Star Tiffany: Hello, and welcome to "Marketplace -- Know Your Rights 101: How to Appeal a Denial or Eligibility of People with Chronic Conditions." My name is Star Tiffany. Along with my colleague, Joanna Hathaway, we will be running today's web forum. Closed captioning will be available throughout today's web forum. Steve Clark, with Home Team Captions, will be providing realtime captioning. The closed captioning text will be available in the media viewer panel. The media viewer panel can be accessed by clicking an icon that looks like a small circle with a filmstrip running through it. On a PC this can be found in the top right-hand corner of the screen. On a Mac it should be located in the bottom right corner of your screen. In that media viewer panel, on the bottom right-hand corner, you will see a link that reads "show/hide header." Go ahead and click on that. What that will do is get rid of that top part, and you will be able to see more of that text Steve is typing in for us.

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The audio portion of the web forum can be heard through your computer speakers or a headset plugged into your computer. If at any time you have technical difficulties regarding audio, please send a question to the Q&A panel and Joanna and I will provide the teleconference center number to you. Once the web forum ends, a survey evaluation will open in a new window. Please take a moment to complete the evaluation as we need your feedback to improve our web forum.

The recording and presentation slides will be posted on our website at www.dialogue4Health.org.

We would like to invite you to connect with us via Twitter and Facebook. Both of those links are on the screen now. Our handle is @dialogue4health for both of them.

We are encouraging you to ask questions throughout today's presentation. To do so, simply click the question mark icon, type your question in and hit send. Please send your question to all panelists. We will be addressing questions both throughout and at the end of the presentation.

Again, if your window collapses, click on that icon with the world icon and the filmstrip.

It is my pleasure to introduce our moderator, An Nguyen. A program manager at the National Network of Public Health Institutes, she leads the Workforce and Leadership Development Projects and Initiatives and manages NNPHI's health disparities programming. NNPHI programs and projects that Ms. Nguyen manages include the Public Health Leadership Society; Toolkit for Health and Resilience in Vulnerable Environments, THRIVE; Bristol-Myers Squibb Foundation Together on Diabetes Initiative; Robert Wood Johnson Foundation Project on Public Health Nursing; and various CDC workforce development projects.

Ms. Nguyen holds a master of health administration from the Tulane University School of Public Health and Tropical Medicine in New Orleans. An, please go ahead.

>> An Nguyen: Good afternoon. Depending on those that are where you are in the country. Thanks, Star, so much for that kind introduction. We want to welcome you all to today's forum, which is brought to you by, in part with support from the Bristol-Myers Squibb Foundation Together on

Diabetes Initiative, Harvard Law School Center for Health Law and Policy, and the National Network of Public Health Institutes.

A little description from our sponsors today. We'll be hearing from two speakers today from the Center for Health Law and Policy of Harvard Law School, and this is a quick description of their center, which advocates for legal, regulatory and policy reforms to improve the health of underserved populations, with a focus on the needs of low-income people living with chronic illnesses and disabilities.

You can visit various social media that they hold. Their website is www.chlpi.org. Or visit their Facebook page, which the website is listed on your screen. And their Twitter handle you're welcome to follow, which is @Harvard CHLPI.

We also invite you to visit the NNPHI on our website at www.nnphi.org or follow us on our Twitter handle @NNPHI_.org. The objectives, discuss potential coverage barriers; outline major ways to contest coverage decisions through the appeals process; and to understand how to appeal a denial of eligibility of coverage.

As mentioned earlier on this call, if you have any questions throughout the web forum, we ask that you submit them through the Q&A feature as described on the screen.

If for any reason any of the windows closes, you can access the closed captioning piece of the web platform as described on the screen.

I'd like to introduce to you all our speakers for today's call. First Maggie Morgan, who is the former health law and policy fellow at the Center for Health Law and Policy at Harvard Law School. Invite you to read her bio on the screen.

And she'll be joined by Malinda Ellwood, who is the clinical instructor of law at the Health Law and Policy Clinic. I also invite you to read her bio on the screen. Those bios are also available on the website.

Another reminder how to submit questions.

With that, I will pass it off to Malinda, who will start us with her presentation.

>> Malinda Ellwood: All right, everybody. Thank you so much for having me today. We really appreciate being able to be here and talk to you a little bit about some issues concerning the Affordable Care Act. I know that all of you are probably extremely familiar with the ACA, and probably you feel you've heard enough about it to last you a lifetime. But I do think it is an incredibly important piece of legislation, something that is continuously evolving, as you all know, and something that a friend of mine compared it to trying to fly a plane as you're putting the plane together. I do think it's been quite a complicated process, and there's a lot to understand. For today, I hope we can teach you something a little new and talk about what happens in the next phase.

We spent a really long time in our communities kind of thinking about enrollment, how do I enroll, how do I make sure I get the right coverage. Now we're moving on to this next phase of thinking about the Affordable Care Act. OK, now I enrolled in a qualified health plan. What happens next? That is what I will talk to you about today.

Sorry about that, folks.

There are four things I'm going to share with you today. One is what do I do if I want to change my health plan? I have a qualified health plan; it's not the right one; I want to change. Are there options for me?

The second one that is important to understand is what happens if I don't pay my premium? What will happen? What will the consequence be, if any?

Third, what if I'm denied benefits? What if there's something I feel I need from my health and my insurance plan is not covering it?

The fourth thing that is really crucial, we're starting to feel out among the advocates, is understanding health plans are not permitted to discriminate based on health status. I hope we can all have a great discussion at the end about what that really means.

The first thing I want to talk about that is really important, now that you enrolled in coverage, you or your client, it is absolutely critical to be sure to keep and review all of your plan documents.

What I have on the screen here is two different things really. When we're going through the open enrollment period, probably the thing you were most likely to see is this thing on the left, which is the summary of benefits and coverage. That was a helpful document. As you can see if you zoom in, it talks about what is the out-of-pocket maximum, what is the deductible. Those are really critical pieces.

Again, this is a summary of benefits and coverage, so it's not going to give you a whole lot of information about how your health coverage really works.

On the right-hand side, what I have is an example of an actual member letter, which you all should receive either electronically or through the mail, and that's going to have your actual plan documents. Sometimes this letter has a packet included with it that you should definitely keep; sometimes it directs you to go online and set up your account; or both.

The critical piece is that you really want to make sure you maintain all of the documentation that your plan sends you, because it will be really critical in understanding how your benefits work, how to appeal a decision, kind of what to expect from your health plan.

To review, make sure you keep all of the plan documentation sent by your insurer and become familiar with your qualified health plan's process for appeals.

I want to clarify, today we're talking about health plans you may have bought on the marketplace. Remember, those are qualified health plans available either through the federal marketplace or your state-based marketplace. There could be a slightly different process or plans that you have through your employer and through Medicaid. We're focusing on the marketplace plans. This a good idea for any plan that you have. Keeping copies of all the plan documents in a place where you can access them again as needed.

Then we all kind of received those, if you've gone to the doctor, you have a health plan, you probably received something in the mail that says document a particular claim or service. The bottom line, you really want to hold onto all that paperwork, because that's really critical to you in case you need to appeal a decision, which is what we'll talk about today.

Now that you know that, what happens after you've already enrolled in a qualified plan, health plan, and you want to change your plan? Well, unfortunately, the answer is now that the open enrollment period has ended, you really can't change your health plan or enroll in another health plan unless you qualify for something called a special enrollment period. What that really means is you need to have experienced some sort of qualifying event. I've given examples. For example, things like you have a change in income. So you're already enrolled in a marketplace plan, but your income

goes way up, so you're no longer eligible for those tax credits. APTC stands for advanced premium tax credit. You lose eligibility for other coverage. Maybe you were getting coverage through employer, all of a sudden you lose your job and lose coverage.

You experience a complex situation. That means, I'm sure all of you are familiar with this, open enrollment does not go as smoothly as we hoped, if you were experiencing technical difficulty during the open enrollment period, you may be eligible for a special enrollment period.

If you move to another state, you have a child or you have recently been released from prison, these are qualifying events that entitle you to a special enrollment period. These events, usually you need to ask for this special enrollment period within 60 days of when it happens, then you have 60 days from the date of the event for application into new coverage.

Again, it's really important that you understand that unless you are experiencing one of these particular events, you're not going to be eligible to enroll or change your plan. That's part of how the health coverage system works.

We do know there will be a new open enrollment period beginning this November, through next February. That is when you can change plans if you're not satisfied with your current coverage.

I would say, bottom line, if you think you may have a reason to change plans, something has happened, it doesn't hurt to apply for a special enrollment period. Then, if you're not granted it, you can appeal that decision or you can choose to keep your current coverage.

Next slide. Again, when you apply for a special enrollment period, first you apply through the healthcare.gov or Marketplace Call Center or your state-based marketplace, if your state is one of the ones that created its own marketplace. Again, you have to apply within 60 days of your qualifying

event. In some cases, if you know you are going to lose your job you may be able to apply for a special enrollment period before then.

Once your special enrollment period is approved, you can apply for those credits and on the marketplace just as you would normally during open enrollment.

Again, if you ask for a special enrollment period, it's not approved, you can appeal that decision through the marketplace, and Maggie will talk about that a little later.

Here I have some resources that you can check out. I won't go through them now, to maximize the time together. Please, do check these out if you have any questions.

Next is what tends to happen, what happens after you've already enrolled in a qualified health plan, and you don't pay your premiums? Well, I think that's important to consider. I think there are a few things you want to think about in this situation. The first is what's happening? Why aren't you able to pay your premium? If you're not paying your premiums because you're now making less money than before, you want to report that change to the marketplace immediately, because again, you may qualify for a special enrollment period and you may be able to access increased amounts of premium tax credits, or if your income is low enough and you're in an expansion state you may be able to access Medicaid. That's point number one to keep in mind.

The second thing to keep in mind is if your income is not changed and you still don't pay your premiums and you are receiving tax credits, if you paid at least one premium payment, that is if since the time you've enrolled you paid at least one premium, you have to get at least a 90-day grace period to sort of catch up on them. What that means is that you have about three months of a period

where you don't have to pay your premiums and nothing will happen necessarily, except that for the first month the plan will continue to pay all your providers.

Let's say it's March, you haven't paid your premium yet, but you paid it for February. That means your provider or qualified health plan will continue to pay the claims at your doctor's offices. After that first month, even though you won't lose your coverage, the insurance company has the right to stop paying the providers. That means the providers may tell you they don't want to work with you anymore or they are concerned about you not having coverage. So again, even though you won't lose your coverage for the full three months after that first month, the insurance company may decide not to keep paying your providers. That's your providers. That's a decision insurance companies make on their own.

If you pay your premiums back in full, plans will cover services during the last two months of the grace period. If you catch up on the premiums after that period, they will cover all of the services just as they normally would.

At the same time, if you don't pay your premiums back and you did get services during that period, that grace period when you weren't paying, you may ultimately be responsible for those costs. Those are important things to keep in mind.

One last thing is that I talked about how you qualified for a special enrollment period. Unfortunately, if you decide, or if you're unable to pay your premiums and your income hasn't changed, you don't qualify for special enrollment period. Just because you decide not to pay your premiums and you get dropped from coverage, unfortunately, that's not enough of a qualifying event to get you a special enrollment period. You can't, unfortunately, just decide not to pay your premiums

in order to change your plan. That won't work. You have to wait until the next open enrollment period to re-enroll in a plan.

What happens after you have enrolled in a qualified health plan and are denied benefits? This is what I want to get into, which is really important.

The bottom line, if you're denied coverage for health services by qualified health plan you have the right to appeal. What do I mean by that? What decisions can be appealed? Well, if your health plan tells you they want to end your coverage, maybe there's a dispute whether you paid your premium, you can appeal that decision. Most commonly, decisions by your health plan not to pay for a medical service you received. For example, maybe your doctor recommends a service, you get that service, then all of a sudden you get a notice from your health plan saying they don't think it was medically necessary, they don't want to pay for it. You can appeal that. Decisions about prior authorizations. That's probably something we're all too familiar with. If there's a particular service you need, your health plan requires prior authorization, they deny that prior authorization, you can in fact appeal that as well.

Finally, we'll go into a little more detail on this as well, you can appeal the decisions about coverage of prescription drugs. I will talk more about this, but the thing to know here, even if there are particular drugs or medications that you need for your chronic illness, that are not covered by your plan, they have to have some sort of exceptions process where you can make the case that you want to have that drug covered.

Of course, decisions not to cover urgent care, meaning not to cover something that they feel like is immediately important to your health, those kinds of decisions have to be made within 72

hours. You will see on this slide, there are various other time frames for when your health plan has to make a decision about other kinds of issues that you requested them to think about.

How do you file an appeal? What's the process? Remember we talked about how important it is to keep your plan documents. Every plan has to give you clear, easy-to-understand information about what their process is for appealing. The reality is that every health plan may have a slightly different process, even though they have to meet most of the same rules.

The first place to look is at the member handbook, for every marketplace handbook has to tell you how to appeal if the plan won't cover a health service. If the qualified health plan, if you received a notice it's not going to cover a service, it has to notify you in writing. This has to include information why they're saying they don't need to cover the service, how you can appeal and what the time frame is for that process.

In every state, we'll talk about this a little more depth, in every state insurance plans must have a process to review within the insurance company, you're applying for the insurance company to re-evaluate the decision. If you lose that appeal, you also have to the right to get an external appeal. We'll talk more about that. It's a review by independent agency, somebody not associated with the health plan who can say whether the health plan's denial was justified, or denial of appeal.

Another critical thing to understand is that often this is a process where you need your provider's help, you need help from the medical provider, to provide documentation for why the service is or was necessary. Make sure you're in contact with your provider about any documentation you may need from them to go forward.

I will also talk at the end about resources, places to go for help with an appeal. Because you do have the right to have someone assist you with that. That's something that the health plan has to allow.

Again, key point here, refer back to your health plan's documentation. I'm an attorney; don't give me too hard of a time. I have to say, it is critical to follow whatever the directions are for filing an appeal, because there are a lot of technicalities, ways for insurance plans to wiggle out of their coverage obligations. One is sort of you didn't follow the right directions, etc. Really make sure you follow the directions, whatever those may be. If you have questions about those directions, don't hesitate to ask the health plan. They have an obligation to tell you how the process works.

Appealing a qualified health decision. You've gotten a decision from your health plan that is somehow adverse to you. They're not going to cover a service. Maybe you haven't received a service, they've told you they won't cover it. There are specific time frames for each of these processes, and in general you will only have a specified amount of time to file an appeal once you get that decision. Usually that amount of time is about 180 days. It's likely you have to follow the internal process first.

I talked about how you have to pursue as an appeal within the insurance plan, they re-evaluate their own decision. That decision on your appeal has to be made within 30 days if it's the service you haven't yet received.

Again, the difference, let's say I think I need a particular medical service, haven't received it, I asked the health plan to cover. They say no; you appeal. They have to tell you within 30 days if they are going to change their mind.

If you received something, say you thought it was covered, you already obtained a particular medical service, your qualified health plan has to make a decision on that appeal within 60 days.

Ultimately, if you disagree, say you appeal the decision, the health plan still says no, then you have the right to appeal this issue externally, through independent third party.

The process, who is the independent third party varies by state, even within the federal marketplace. You need to look at the notice that you received from your qualified health plan. That should explain to you how to file this external appeal and what the time frame is. If you have questions, or they haven't given you the information, you have the right to call and ask for it. They should give it to you automatically.

This external review process should be decided as soon as possible, usually about 60 days. Again, time frames may vary. Again, you do have the right to appoint an authorized representative to help you.

Expedited appeals. We talked about the kind of general process, but occasionally there's a drug or service or something that you need, that your provider really thinks is necessary to avoid severe pain or which seriously jeopardizes your life or ability to regain maximum function. These are called urgent care benefits. If it's really a service that you and your provider think is seriously going to jeopardize your health if not rendered immediately, you can request an expedited external appeal.

If you are denied this benefit, it's urgent, you do not have to wait for the insurer to complete their process. You can file for the external review at the same time. The external review decision must be made as quickly as your medical condition requires, at least four business days.

This is a process to kind of bypass that time frame I talked about. If it's something that you and your provider feel it will jeopardize your life, you can apply to see if you can get expedited external appeal.

Next slide. I talked about something called the exceptions process. In the HIV community, as with diabetes, the kinds of drugs you need that you depend on are really vital to your life and to you, your ability to maintain health. Occasionally, you have a particular drug that your doctor recommends that, for whatever reason, is not covered or not listed on your health plan's formulary.

There is a requirement that just because a drug is not listed on the formulary, everybody has a right to appeal through exceptions process and request that your health plan cover whatever drug your provider is recommending, even if it's not on the formulary. Each plan's exceptions process may be slightly different, but in general the kinds of things you need to demonstrate in order to obtain coverage or to successfully make it through the exceptions process are you need to show that whatever other drugs on the formulary have not been or will not be as effective, or that any particular alternative drug you could take that is covered by your plan is likely to cause harmful side effects.

If it's an issue where you want a different dosage or number of dosage that's beyond the limits that may be inherent in your plan, you need to show this dosage that the plan covers doesn't work or, based on your physical or mental health, you need a different dosage. These are the kinds of things you have to demonstrate with, hopefully, help from your provider in order to be successful in the exceptions process.

It's important to note, if you get denied, if your insurance plan says even though you went through the exceptions process we're still not covering it, you can appeal that decision in the same way I've described for other kinds of decisions.

Getting help with an appeal. This is really complicated. Appeals can be difficult. You can call various numbers that I have listed here. Many states have something called a consumer assistance program, CAP program, or Department of Insurance may be able to help you. You need to be able to access materials. If you don't speak English, you can call and ask an interpreter.

You always have the right to appoint an authorized representative to help you, a legal aid attorney, friend or advocate or someone else you think would be useful to help you through this process.

I've listed fact sheets from healthcare.gov that again explain the process I've described in a little more detail.

To say, we don't have enough time here to go through the process for what happens under Medicaid, I have been talking about those private insurance plans that you apply for during open enrollment through the marketplace. Many of you may also in the alternative be on Medicaid, and in Medicaid the processes for appeal are different. They can vary by state. You do have a few general requirements that apply across the board. The first is that if you have requested prior authorization, your Medicaid plan has to make that decision on whether your prior authorization request will be approved within 24 hours.

Second, all Medicaid beneficiaries are entitled to 72 hours worth of emergency supply of medication if they're not able to act on your priority authorization request.

You're constitutionally required to notice and a hearing. If your Medicaid plan makes a decision that is adverse to you, you also have the right to appeal in a process that may be quite similar to what I described, or slightly different, depending. The point is that you do have a right to a notice and hearing.

Similarly, if you have a Medicaid plan that has a managed care plan, if you're in Florida or other states where you have a Medicaid managed care plan, you may first have to do an appeal through the managed care plan, like the internal review process I described before. Those are things to keep in mind.

One last point about Medicaid, as far as eligibility is concerned, I talked about how you need to qualify for a special event to re-enroll or change marketplace plan. With Medicaid, you can enroll at any time. There's no such thing as open enrollment as far as your Medicaid program is concerned.

This is something that is really, really critical for people to understand and something relatively new to the world of health insurance, and that is health plans cannot discriminate.

The question is what does that really mean? This is important to understand. The basic concept is that plans can no longer exclude people from coverage because of a pre-existing condition, like diabetes, like hepatitis C, like HIV. Plans are not able to say we're not going to cover you because of those illnesses, or we're not going to cover that illness once you get on.

In addition, there are rules that apply specifically to the marketplace plans that I've been describing, and those are that these plans again cannot discriminate against people based on race, color, national origin, sexual orientation, gender identity, disability or other health condition. Those are really important, a right that you need to keep in mind.

This is another piece of really important to delve into the sex discrimination piece. The ACA expanded protection against discrimination based on sex, sexual orientation or gender identity. This means women cannot be charged more than men for healthcare. This has always been a huge, huge problem, because you can literally have a woman and a man having the exact same plan, same coverage. Guess what -- women were charged three times the amount of premium, even though it was the exact same coverage. This is a huge victory this is no longer the case.

Pregnancy and marital status cannot be a source of unequal treatment. Plans are required to cover maternity care. Plans cannot discriminate based on sexual orientation or transgendered status. A hugely important piece that the ACA implemented.

This means QHPs cannot discriminate in plan design. You can't have a health plan that has been designed as far as the benefits to discourage enrollment by people with significant health needs. If you have a plan and you see that it doesn't cover any of the medications that you need for your diabetes care, that could be a very clear signal of discrimination. Or similarly, if you are finding that all of the medications that you need, all durable medical equipment, everything is on the highest level of expense or highest tier, for example, drugs, of expense, that is also discrimination.

With HIV, we recently filed a complaint with the Office of Civil Rights alleging that many plans in Florida were discriminating against this community, because literally all of the HIV medications were on the highest cost-sharing tier, required about 40% co-insurance. Again, the issue is that it has the effect of discouraging enrollment of people with significant health needs, like HIV or diabetes. It is important to remember that we're still awaiting some final guidance from the Department of Health

and Human Services about exactly how some of these anti-discrimination provisions will work. Keep your eyes on what may happen with that.

That's it for me. I'm going to turn it over to Maggie, if we can move the slide deck. There we go. Sorry about that. Some technical difficulties.

Examples of potential issues, inadequate formulary coverage, if your plans aren't covering insulin. Placing all diabetes drugs on the highest cost-sharing tiers. Or lack of transparency. What I mean is we saw in many of the marketplaces, for example, plans that wouldn't publish their full formularies. When you were on the, marketplace, you clicked a particular formulary for a plan, the fine print said this is a list of commonly used medications. Oftentimes, they left out the more expensive, commonly used medications. Lack of transparency can be indicative of a plan trying to get around this new requirement not to cover pre-existing conditions or people traditionally more expensive to cover.

What can you do if you think you're being discriminated against? Two options. I encourage you to do both. One, file a complaint with the Office of Civil Rights. There's a way to access those from the slide deck. Second, you have the option to complain to your Department of Insurance about your plan or whatever is happening with your plan.

There are two ways to think about that. One is, as an individual you have a right to file a complaint. If you're part of a larger organization or advocacy group, it may make sense to try to schedule a meeting with the Department of Insurance to share some of the issues your are seeing, some concerns about the coverage options. Ultimately, they could be a real ally, and it makes sense to try to develop that relationship and see if you can together make it a more productive one.

Last thing is that with an appeal, you can also file a grievance with your health plan.

Here are more resources.

I really appreciate you letting me talk with you all. I will turn it back to An and Maggie. Thank you.

>> Maggie Morgan: Hi, everyone. Malinda talked about a lot of the major issues people are going to be facing at this moment in time, given that open enrollment for the 2014 has ended, and that people are going to be experiencing mostly issues with their coverage.

What I'm going to talk about are issues with enrollment in the first place in qualified health plan, and the open enrollment period for 2015 begins in November of this year, and there will be people who haven't signed up already, who are seeking insurance, who will sign up. There are also going to be people whose eligibility for premium tax credits and subsidies has changed. So it's important to know what are your rights and what are the procedures that you need to undertake if you're going to appeal.

The first question is what types of decisions regarding enrollment can you appeal. Well, there are several important categories here. You can appeal a decision saying you're not eligible for Medicaid or for the Children's Health Insurance Program. A big one is that if you receive a decision saying you're not eligible for subsidies or premium tax credits on the marketplace to assist you in securing affordable coverage. Or a third related issue is that if you receive a decision saying you're eligible for a different amount of subsidy or tax credit than you think you're entitled to receive based on income, if you receive a lower amount of subsidies than you should get based on your income.

Another interesting category is that if you apply for an exemption from the individual mandate, then they say that you are not exempt, you can appeal that decision.

Then, as Malinda talked about, when she was talking about special enrollment periods, if you try to enroll in the marketplace plan outside of the regular open enrollment period and you're turned down, you can also appeal that decision.

So back up one slide. If you have applied for subsidies or applied for an exemption from the individual mandate or other categories, you have the right to receive notice of your initial eligibility decision.

It can come in the mail, or you can consent to have it sent via e-mail. This notice is really important because it will tell you where you should send your appeal. This will vary based on what state you're living in, whether you're under a federally facilitated marketplace or state marketplace. Be sure to take a look at the notice and keep copies of that.

Once you are not satisfied with the decision that was made and you want to appeal, you have some procedural rights. You have the right to receive notice that your appeals request was received. And you have the right to an appeals process that is fully accessible to people with disabilities, through accessible websites, auxiliary aids, or if you have a limited English proficiency, you have the right to receive oral interpretation, written translation, other tag lines and non-English languages to assist you in understanding the appeals process.

Now, what do you do if you want to file an appeal on the marketplace? Three options. One is online at healthcare.gov. If you log into your account there, you can file an appeal. Over the phone

as well. There's a number. You can also write a letter through regular mail. Then there's a link there that you can access information.

Now, the timeline for filing an appeal, if you live in a state with a federally facilitated marketplace, you have 90 days to file an appeals request from the date that you receive notice of your eligibility determination. For example, if you're turned down for premium tax credit, you have 90 days to appeal that decision.

State-based marketplaces can choose their state's Medicaid deadline as long as it's at least 30 days.

Once you do file an appeals request, what are the processes that you have to undergo? Well, first step for many people will be the informal resolution process. This is required for federally facilitated marketplaces. If you call the marketplace and you let them know about your problem, they can try to resolve it without going to a formal hearing.

If you're not satisfied with the result, if your needs are not met, you can request a formal hearing with more procedures.

The informal process is not required for state-based marketplaces, so it will depend what state you're in as to what procedures will be used. It's optional for Medicaid agencies who are deciding Medicaid appeals. When you are appealing a Medicaid decision, you do have the right to have a formal hearing, as Malinda had said earlier.

So the appeals hearing, the formal hearing, they're pretty flexible. They can be conducted in person. You can use the telephone or video conferencing technology. You can represent yourself or

have someone else represent you, appoint an authorized representative to act on your behalf, as Malinda mentioned. There are several possibilities here.

Now, there are also expedited appeals for enrollment issues. If you really need a decision right away, for example, if you're suffering from an illness where you need insurance coverage right away or you need the premium tax credits to afford your insurance, you can apply for expedited appeal. They're available when a longer process can jeopardize the life of the applicant. This is a very discretionary standard, made on a case-by-case basis with attention to the individual facts. If the request is denied, they have to send written notice to the applicant explaining the reasons for the denial and your rights and proceedings. Then you are not denied completely; you just have to go through the regular appeals process.

If you've made an appeal, say you're appealing your tax credits or another one of the decisions that I listed earlier, what do you do while it's pending? Do you lose your benefits? Well, no. That's the short answer.

If you're already receiving benefits, you're allowed to keep the benefits pending resolution of the appeal. Now, this is with the QHPs on the marketplace. This is different from most Medicaid programs, where consumers have to file a request within 10 days of determination to keep their benefits.

There are situations where the marketplace is allowed to hear Medicaid appeals, like when the marketplace makes initial eligibility determination, then they also hear the appeals. They have to follow the Medicaid rules on the issue. You'll have to consult your state Medicaid rules, if it involves a Medicaid appeal.

The consumer, if they want to keep their plan during the appeals process, they do have to keep paying their premiums during that time.

Say that you do have an issue with your tax credits, that's what you're appealing, and you are saying that you need a higher amount of tax credits. Well, you can keep your existing tax credits during the appeals process, but if you do appeal the amount, if it's determined in the end you are eligible for a lower amount of tax credits than you are receiving at present, you will have to pay the benefits back on your taxes the following year.

Because this is a significant hardship for people who may not be anticipating this, you have to be informed of this possible tax issue before you're allowed to receive these benefits while your appeal is pending.

When will you be receiving your decision? Marketplace eligibility appeals must be decided within 90 days of the appeals request. This also includes time spent on the informal resolution process. Now, if you're in a state-based marketplace, and you disagree with the appeals decision, you have the option of escalating this appeal to HHS for decision. You have 30 days to do this after you receive the decision. State Medicaid agencies that delegate Medicaid appeals to the marketplace can choose to review the marketplace's legal conclusions. They can't conduct a finding of facts, but they can conduct a finding of the law.

After you win an appeal, what happens? Say that you are -- you appealed the amount of subsidies and tax credits you were supposed to receive, you say you were supposed to receive a higher amount, then the appeals entity agrees with you? Well, if they made a mistake in deciding

your eligibility in the first place, you can go back and receive benefits going back to the date that that mistake was made.

If you choose to receive these retroactive benefits, you will still be required to pay premiums for that passed time period. You are not absolved of the duty to pay those premiums.

That was for the marketplace plans. If your appeal concerns Medicaid eligibility, the rules for retroactive coverage will follow the state's individual Medicaid rules.

I think I have reached the end of my slides. So now I will turn it over to An.

>> An Nguyen: Thank you so much, Malinda and Maggie. Right now, we'll open it up for questions. If you have any questions, please use the Q&A feature on the right column of your screen.

There's a question that came in from Richard Lupo. I think, Malinda, you'd probably be the best person to answer it. If at any time after enrollment your income changes, is there -- is it possible to change the company and/or plans, or if there's any tips that you can provide the audience in regards to that question.

>> Malinda Ellwood: Sure. That's a good question. As all questions are, it's probably more complicated than you might think. The answer -- the question is, as I understand it, if my income changes, am I able to change to a different plan. The answer is it depends. These are the things it depends on: If you're in a marketplace plan, and your income changes to such a degree that you qualify for different amounts of cost sharing, then yes, you can, you should be able to apply for a different enrollment period and have the option of changing plans. If your income changes, you never enrolled in a plan to begin with, for whatever reason you didn't enroll during the open enrollment period, your income goes below what you thought it would be be, you might be eligible for tax credits.

Unfortunately, that is not enough to allow you to enroll in the marketplace, if you missed the open enrollment.

The catch, if you did not enroll in the marketplace but you did apply for an exception to the mandate that says you have to have coverage, let's say you had really low income, you applied for exception, you applied for exemption saying you don't have to pay the fee for not having health insurance, if your income increases to a degree that all of a sudden that no longer applies to you, you don't qualify for that exemption anymore, you could apply to the marketplace for the first time to see if you might be eligible to purchase coverage.

The other thing to say is that if your income, if you've never applied in a marketplace plan, your income is way down or other things happen, you can always try to apply for Medicaid and see if you may be eligible. When in doubt, always ask your marketplace plan to see if it's a possibility, or your marketplace.

>> An Nguyen: Thank you very much for that. Similar related question, what happens if someone can't pay their premiums for their marketplace plans?

>> Malinda Ellwood: I don't know if I can -- I can't scroll the slides. That's a really good question. The answer is, again, complicated. If you can't pay your premiums because your income has decreased or increased, so you might qualify for different kinds of tax sharing credits, then you may be able to apply again and get a different plan.

However, if you can't pay your premiums, there isn't a particular reason, your income hasn't changed, for whatever reason it is unaffordable to you, not paying your premium means that you have a three-month grace period, three months to try to find the resources to pay them, during that grace

period, that first month if you are unable to pay your premium, your plan will still continue to pay your providers, to pay your doctors. After that first month, your plan can say, All right, I'm not going to drop you from coverage, but we're no longer going to pay for your doctors' bills, so you have to get retroactively paid for that.

If that's the case, again, after that three-month period if you are able to pay back all of the premiums you owe, the plan will retroactively cover whatever they didn't cover during that period. In the same way, if your plan did cover services during that period and you never were able to pay back your premium, you may be responsible for that.

>> An Nguyen: Thanks. A question from Nancy Hagerty, what if I enrolled in a plan that my provider was part of, and now he's no longer part of the network? Can I change plans?

>> Malinda Ellwood: That's a really good question. Initially, during the open enrollment period, there was a special exemption if you chose a plan your provider was not a member of. You did have an exemption. I think at this point, because your provider disenrolls from the plan, that is not enough of a reason to give you special enrollment period. States may have their own exemptions. This may be the case that your state has its own exemption. Some states may be more generous.

I encourage you to check with your marketplace or plan to see; perhaps you can change plans within the carrier. If you have one Blue Cross-Blue Shield, your plan might let you change because your provider is not longer covered. I don't know if that is enough of a kind of guarantee of right to change plans. I would contact your state marketplace to find out more, and contact your plan as well.

>> An Nguyen: A question from Linley Bassett. Besides timelines allowed for decisions, what's the implication for state's decision to delegate or not delegate appeals authorities to an appeals entity? And where can I find out whether my state has delegated appeals authority.

>> Maggie Morgan: I think the answer is your marketplace should let you know who is handling appeals. It could be the case that your marketplace has an entity handling the appeals for Medicaid, and the Medicaid office for particular Medicaid programs. That's a very state-specific question. I would follow up either the federal marketplace should have information on each state, how the appeals processes work. Then similarly, if you have a state-based or partnership-based marketplace, check for information there.

>> An Nguyen: Great. Thanks. Do I have to qualify for special enrollment period in order to qualify for Medicaid?

>> Malinda Ellwood: The answer is no. The question should have been can you enroll in Medicaid. The answer is you can enroll in Medicaid, or try to, at any time. Medicaid has different rules, meaning that for the private insurance, or the marketplace, you can only apply in general during open enrollment, unless you qualify for a special enrollment period, but Medicaid you can apply at any time during the year.

>> An Nguyen: Another question we received is how do I know whether something I am experiencing with my plan counts as discrimination?

>> Malinda Ellwood: That is a really difficult question. We don't have a specific answer, except to say that groups around the country, advocates, individuals, are attempting to figure out what this means. The reality is in some cases we are waiting for HHS to issue for direct guidance about what

the boundaries of discrimination will be and how they look at qualified health plans to determine whether some benefits structures may be discriminatory. The other way is to test the boundaries. You need to find out, file a complaint with your Department of Insurance, talk to an attorney, see if you can move the kind of advocacy tide forward in prosecuting and understanding when plans are trying to get around this new requirement that they cover everybody regardless of pre-existing condition.

>> An Nguyen: Great. The final question -- no, a few more questions. If you like your plan on November 15, do you stay on your plan or should you shop around?

>> Malinda Ellwood: That's up to you. If you feel like there are health needs that you might not anticipate now, you want to look around, then you can. If you want to keep your plan, because you're satisfied with it, I think the two ways to evaluate health plans, number one, what are the costs to you? Might you find a cheaper plan that covers the same services or things you like in your current plan? Or is it possible that there are services, you most like in your current plan, but there are some services you wish it would cover more effectively. In which case you may want to look around.

That's an individually based question. I can't really answer that aside from saying it's up to you. There's probably no harm in looking around. If you're satisfied with your current coverage, you may not want to do that.

>> An Nguyen: We've got a question from Lisa Peterson. Her question deals with coverage. Do most plans cover tuberculosis disease or infection treatment? That's the question.

>> Malinda Ellwood: All plans have to cover what's called the essential health benefits, which includes chronic disease management. So I'm not aware of plans on the marketplace certainly being

able to exclude coverage for tuberculosis. I would say for TB most of the marketplace plans should cover this. They may have authorization process in terms of what they can cover in terms of coverage or who can access treatment. I'm not as familiar with TB. I don't know why plans would be able to exclude that, unless it's something I'm not familiar with.

The other caveat, if this is a provider asking, you want to make sure that you do take, that you can in whatever plan's network. You have to negotiate contracts with the insurance plans. The plans may vary, and reimbursement or the kinds of chronic disease management or treatment they cover. One may include, for example, the treatment and case management. One may have a different chronic disease benefit structure. It varies by plans. I imagine all plans have to cover some form of tuberculosis treatment, and it is up to you to negotiate with the plans how you get paid for that as a third party biller.

>> An Nguyen: Can health plans raise their premium rates mid-year?

>> Malinda Ellwood: Not that I'm aware of. They do have to go through a process when increasing premiums. There may be -- I can follow up and get back to you. There may be a small window. But for the most part, they're not allowed to do that. They have to go through a process when increasing premiums.

>> An Nguyen: Richard Lupo is asking, do you think federal markets are doing better than the state markets?

>> Malinda Ellwood: It depends how you evaluate them. There's a question about process. Is the process for the federal marketplace more efficient or more effective than the various states. Again, it depends who you are comparing to. For the most part, states that are implementing their own

marketplaces tend to be where there's more comprehensive coverage, that expanded Medicaid, like New York, Massachusetts, California. In that sense, there's a way in which those marketplaces are actually better. At the same time, it really varies by states. Massachusetts we've always had our own marketplace for a long time, but did experience significant backlog, as did other states.

I guess I would say I don't have a clear answer on that, except to say there are different criteria to look at. All states have things they've done well and others they can greatly improve on.

>> An Nguyen: The final question, do you have any tips for what to think about with open enrollment next year for choosing a plan?

>> Malinda Ellwood: Sure. There were a lot of lessons learned from this past open enrollment period. One of the things I encourage you all to do in the chronic disease community, however you define that for yourself, is share with each other and with other navigators what were the things that worked best for enrollment. I've heard a lot about the fact that, really, community-specific methods are really important as far as open enrollment and getting people to understand how the process works.

There's a separate question about your health plans. One of the things that was a shock to some people is really understanding how these cost-sharing structures worked. I pointed to the summary of benefits and coverage at the beginning. There's not a lot of information there. You have to do more digging to understand how the plans operate with respect to your health needs.

When you look at a plan, it is really important, especially, to look at two different things. One is your particular medications, what is that going to cost you? If you have a medication that is on the formulary, but on the highest specialty tier, it's 40% co-insurance, that's going to be a significant

expense for you that you really need to look at. While the ACA has yearly maximums on out-of-pocket coverage, there's a difference if you have to pay all of that in your first month, versus spread over time. Really important to look at the formularies and cost-sharing structures.

It's important to look at different plans. Plans have different processes. In some cases you may request that they cover services from an out-of-network provider, if it's an out-of-network provider that offers a service nobody else offers. But the reality is you want to be on top of, in preparation for open enrollment, talking to all providers or advising clients to talk to providers, find out what networks will participate in, to be sure to choose a plans that covers your provider, that is affordable to you and covers your medications in the way that you need.

>> An Nguyen: I want to -- that was the last question we received. We are kind of reaching the end of our time on the web forum. I want to thank Maggie and Malinda for speaking on today's web forum, and give a special thank you to our behind-the-scenes people, both Star Tiffany and Joanna Hathaway at Public Health Institute. Thank you to co-funders and sponsors and those who joined us on the web forum.

As we mentioned, these slides and a recording of the web forum will be available on the Dialogue4Health website. They will be available shortly, following the end of this web forum. Please do complete the survey that will pop up on the screen once we've ended this session.

Thank you, everyone. Have a great afternoon.

[Webinar ended at 12:00 p.m. Pacific Time, 3:00 p.m. Eastern Time]